EyeMed VISION CARE®

City of Arlington
EyeMed Select Plan A, Fixed Fee
Voluntary
Option 2

Version 4

EyeMed Vision Care in conjunction with Combined Insurance Company of America

Vision Care Services	Member Cost	Out-of-Network
Exam with Dilation as Necessary	$10 Copay	$40
Contact Lens Fit and Follow-Up: (Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)		
Standard Contact Lens Fit and Follow-Up:	$0 Copay, Paid-in-full fit and two follow-up visits	$40
Premium Contact Lens Fit and Follow-Up:	$0 Copay, 10% off retail price, then apply $40 allowance	$40
Frames: Any available frame at provider location	$0 Copay; $130 Allowance, 20% off balance over $130	$80
Standard Plastic Lenses		
Single Vision	$10 Copay	$40
Bifocal	$10 Copay	$60
Trifocal	$10 Copay	$80
Lenticular	$10 Copay	$80
Standard Progressive Lens**	$10 Copay	$60
Premium Progressive Lens**	$10, 80% of Charge less $120 Allowance	$60
Lens Options:		
UV Treatment	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Plastic Scratch Coating	$0	$8
Standard Polycarbonate - Adults	$40	N/A
Standard Polycarbonate - Kids under 19	$0	$20
Standard Anti-Reflective Coating	$45	N/A
Polarized	20% off Retail Price	N/A
Other Add-Ons	20% off Retail Price	N/A
Contact Lenses *(Contact lens allowance includes materials only)*		
Conventional	$0 Copay; $105 allowance, 15% off balance over $105	$105
Disposable	$0 Copay; $105 allowance, plus balance over $105	$105
Medically Necessary	$0 Copay, Paid-in-Full	$210
Laser Vision Correction Lasik or PRK from U.S. Laser Network	15% off retail price or 5% off promotional price	N/A
Additional Pairs Benefit:	Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used	N/A
Frequency:		
Examination	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	
Frame	Once every 24 months	
Monthly Rate		
Subscriber	$4.72	
Subscriber + 1	$9.90	
Subscriber + Family	$15.09	

All plans are based on a 48-month contract term and 48-month rate guarantee

** Standard Progressive Lens covered - fund Premium Progressive as a Standard

Additional Discounts:
Member receives a 20% discount on items not covered by the plan at network Providers, which cannot be combined with any other discounts or promotional offers. Discount does not apply to EyeMed Provider's professional services, or contact lenses.
Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.
After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com.
The contact lens benefit allowance is not applicable to this service.
Benefit Allowances provide no remaining balance for future use within the same Benefit Frequency.
Certain brand name Vision Materials in which the manufacturer imposes a no-discount practice.
Rates are valid only when the quoted plan is the sole stand-alone vision plan offered by the group
Rates are valid for groups domiciled in the State of TX.
Fees quoted will be valid until the 1/1/2011 plan implementation date. Date quoted: 7/12/2010.
Rates assume 100% employee contribution for employees and dependents.
Insured Plans are underwritten by Combined Insurance Company of America, 5050 Broadway, Chicago, IL 60640, except in New York.

Plan Exclusions:
1) Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses; 2) Medical and/or surgical} treatment of the eye, eyes or supporting structures;
3) Any eye or Vision Examination, or any corrective eyewear required by a Policyholder as a condition of employment; Safety eyewear
4) Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
5) Plano (non-prescription) lenses and/or contact lenses; 6) Non-prescription sunglasses; 7) Two pair of glasses in lieu of bifocals;
8) Services or materials provided by any other group benefit plan providing vision care;
9) Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order.
10) Lost or broken lenses, frames, glasses, or contact lenses will not be replaced except in the next Benefit Frequency when Vision Materials would next become available.

If City of Arlington has chosen this benefit design, attach this document to the group application and sign here:

Signature _____ Date _____

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